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AUTHOR	Osher, David; Quinn, Mary Magee; Kendziora, Kimberly; Woodruff, Darren; Rouse, Gerald
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ABSTRACT

This monograph introduces a series on youth with cognitive or behavioral disabilities and the juvenile justice system. The first section discusses the importance of prevention and early intervention to divert youth with disabilities from entering the justice system. It offers examples of such efforts and considers early and later intervention efforts, the importance of family involvement, assessment and evaluation, protective factors to enhance prevention, and prevention and sensitivity in the individual. The second section considers the various disabilities that put youth at greater risk for involvement with the juvenile justice system, especially learning disabilities, emotional/behavioral disorders, and attention deficit (hyperactivity) disorder. The third section discusses the path a youth takes on his or her way through the juvenile justice system. The section addresses issues of co-morbidity, barriers in the justice system, custody/detention, initial appearances, prosecution filing decisions/diversion, cognitive and behavioral disabilities and trial issues, adjudication hearing/trial, post adjudication evaluations, dispositions/sentences, revocations/further dispositions, and training of

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judges, lawyers and others. The last section provides a brief description of the contents of each of the other six monographs in the series. Stressed throughout the monograph is the mission of the juvenile justice system, to protect and rehabilitate youth in trouble, not merely to punish them. (Contains 68 references.) (DB)

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ADDRESSING INVISIBLE BARRIERS:

IMPROVING OUTCOMES FOR YOUTH WITH DISABILITIES IN THE JUVENILE JUSTICE SYSTEM

By

David Osher, Jerry Rouse, Mary Quinn, Kimberly Kendziora, & Darren Woodruff
Senior Advisor John Furman

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Errata

p. 18 misspelled word: co-morbidity

p. 23 incorrect monograph titles:

Best practices for serving court involved youth with learning, attention, and behavioral disabilities. (by Larson & Turner).

Corrections and juvenile justice: Current education practices for youth with behavioral and cognitive disabilities. (by Howell & Woldford).

The role of recreation in preventing youth with behavioral and cognitive disabilities from coming into contact with the juvenile justice system and preventing recidivism. (by Howard & Peniston).

p. 24 incorrect monograph title:

Collaboration in the juvenile justice system and youth service agencies: Improving prevention, providing more efficient services, and reducing recidivism for youth with disabilities. (by Leone, Quinn, & Osher).

Addressing Invisible Barriers:

Improving Outcomes for Youth with Disabilities

In the Juvenile Justice System

David Osher, Ph. D.
Mary Magee Quinn, Ph.D.
Kimberly Kendziora, Ph. D.
Darren Woodruff, Ph.D.

Center for Effective Collaboration and Practice at
The American Institutes for Research

The Honorable Gerald Rouse
President, National Council of Juvenile and Family Court Judges

With Senior Advisor:

John Firman
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Introduction

The Department of Justice's 1999 National Report on Juvenile Offenders and Victims paints an unhealthy picture of juvenile justice outcomes (Snyder & Sickmund, 1999). In 1997, the last year for which data are available, approximately 1 in 5 arrests made by law enforcement agencies involved a juvenile. During that year 2,838,000 youths under 18 -- a little over 9% of the U.S. population ages 10-17 -- were arrested. If current recidivism percentages apply, 46 percent of the males and 27 percent of the females will recidivate.

Many factors affect juvenile justice outcomes. One factor all-too-infrequently addressed is disability, which can place youth at great risk for contact with the juvenile justice system, as well as for poor outcomes once they have come into contact with the juvenile justice system. National studies show that a minimum of 30% to 50% of youth involved in juvenile crimes has special needs (Rutherford, Bullis, Anderson, & Griller-Clark, this series). Unfortunately, many service providers within the juvenile justice system are not sufficiently aware, not trained, or lack the resources to respond appropriately to children and youth with cognitive, emotional, and behavioral disabilities. These disabilities place them at greater risk than their peers for school suspension, school dropout, substance abuse, arrest, restrictive placement, and recidivism (DeMilio, 1989; Lexcen & Redding, 1999; Prescott, 1998).

The Need for Disability-Specific Approaches

In order to make adjudication and placement decisions, a judge, public defender, dispositional advisor, probation officer, and/or other corrections staff need to consider the following information about disability characteristics and effective approaches when choosing appropriate settings.

- *Is there a possibility that, because of a disability, this youth does not understand the charges?*
- *Has the youth received appropriate services at his or her previous school placement? Is there a current IEP? Is the IEP being implemented as written?*
- *Are the needs addressed in the youth's IEP considered and integrated into the consequences determined by the court?*
- *Is an updated or more comprehensive disability or mental health evaluation needed?*
- *Does the correctional setting being considered for this youth have programs that can accommodate and specifically address his or her disability?*
- *Does the youth have some understanding about the disability and a plan to address his or her risk-taking or illegal behaviors?*
- *Do parents (guardians, foster parents, or surrogates), education professionals, correctional program staff, employers, and others involved with the youth understand the youth's disability-related needs? What can they do, collaboratively, to provide the youth with supports to successfully transition back into the community, including an aftercare program?*
- *Are teachers or employers being provided with assistance and knowledge about the range of options they need to address this youth's disabilities or problematic behaviors?*

If there is no documentation of a disability and the youth's family has not indicated a prior diagnosis, the following questions also are pertinent:

- *Has the youth experienced a history of behavioral or learning problems?*
- *Are there aspects of the youth's behavior that warrant a screening for a disability evaluation?*

- *How, if at all, have these issues been addressed by the family or the school? (Garfinkel, 1998)*

The following series of monographs, will address the issue of youth with cognitive or behavioral disabilities and their experiences in the juvenile justice system. If staff in the juvenile justice system (e.g., law enforcement personnel, probation officers, judges, correctional educators, correctional custody and treatment personnel, and youth guidance counselors) receive support in understanding the cognitive and behavioral problems of youth with disabilities, the system will better serve these children. Appropriate responses from those in the system will lead to better outcomes for the children and youth, for their families, and for society as a whole.

Responding to the disabilities of children and youth is consistent with the founding principles of the juvenile justice system, and specifically, the belief that there is a fundamental difference between children and adults. Children are still developing, can be positively influenced by rehabilitation efforts, and therefore need a separate court system to address their needs.

Responding to the Developmental Needs of Children

"Children are developmentally different from adults and therefore children and families need a separate court system to address their legal concerns. They are dependent on adults; they are developing emotionally and cognitively; they are impressionable; they have different levels of understanding than adults. The simple truth that children are not little adults and should not be treated as adults gave rise to the juvenile court almost a century ago and, in more recent times, to the family court. There is a fundamental difference in philosophy between juvenile courts and adult criminal courts. Because young offenders are believed to be particularly malleable and susceptible to moral and social rehabilitation, the juvenile court seeks to rehabilitate juvenile delinquents, thereby preventing future criminal behavior. In contrast, adult criminal courts seek to induce law abiding behavior by means of punishment for wrongdoing." (National Symposium "The Janiculum Project Recommendations", Sponsored by the National Council of Juvenile and Family Court Judges supported by the State Justice Institute and the Office of Juvenile Justice and Delinquency Prevention, Sept. 28-Oct 1, 1997, p. 1)

Recognizing the developmental differences between children and adults, states gave (in the words of Murray and Adeline Levine) "the juvenile court full responsibility for child guidance and child welfare." (1992, p. 101). For the juvenile justice system to be effective it must address the needs of children and youth with disabilities, for the differences among youth can be as profound as the differences between juveniles and adults.

Legislative Foundation for a Disability-Sensitive Juvenile Justice System

A disability-responsive approach to juvenile justice and crime-prevention is consistent with Federal statutes through which Congress (in terms of children and youth) "attempted to address the longstanding discrimination faced by children with disabilities in the U.S." (National Council on Disability, 2000, p.25). Three Federal statutes are particularly relevant here: The Rehabilitation Act, the Americans with Disabilities Act (ADA), and The Individuals with Disabilities Education Act (IDEA).

Section 504 of the Rehabilitation Act prohibits disability discrimination by any recipient of Federal funds (29 U.S.C. § 794). Title II of the ADA prohibits "public entities" from discriminating against a "qualified individual with a disability" on account of that disability. The Supreme Court upheld the application of the ADA to Prisons in *Pennsylvania Department of Corrections v. Yeskey* (118 S.Ct. 1952 (1998), (see sidebar on the Yeskey case). The IDEA establishes the rights of children and youth with disabilities to a free and appropriate public education (FAPE) that addresses their individual needs and does so in the least restrictive environment appropriate (20 U.S.C. § 1412 (a)(5); 20 U.S.C. § 1401 (29); 34 C.F.R. § 300.26). The IDEA implements rights that were established under two landmark Federal Cases, *Pennsylvania Association*

for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania (334 F. Supp. 1257 (E. D. Pa. 1971)); 343 F. Supp. 279 (E. D. Pa. 1972), and *Mills v. Board of Education of the District of Columbia* (348 F. Supp. 866 (D.D.C. 1972)). Placement of a child or youth in a juvenile justice facility does not remove education rights under the IDEA, which covers children and youth until they are 22. Nor does incarceration of a youth in an adult facility remove the protection of the IDEA. There are two specific exceptions to the FAPE requirement for youth sentenced to adult facilities. These exceptions cover students aged 18 through 21 (to the extent that State law does not require that special education and related services under Part B of the Act be provided to students with disabilities) who, in the last educational placement prior to their incarceration in an adult correctional facility were not identified as a being a child with a disability and did not have an IEP (20 U.S.C. § 1412(a)(1)(B)(ii); 34 C.F.R. § 300.311(a).

- The youth is under 18
- The youth is between 18 and 21, but was identified as being a child with a disability and had an Individualized Education Program (IEP) in his or her last education placement before incarceration or before he or she left school; or
- The youth is between 18 and 21 and had been identified as a "child with a disability" under the IDEA, even though he or she did not have an IEP in his or her last educational setting.

The Yeskey Case

Ronald R. Yeskey was convicted of drunk driving, resisting arrest, and other charges, and was initially recommended for sentencing to a Motivational Boot Camp for first-time offenders. He could have been eligible for parole in six months. He was disqualified from the Boot Camp program, which requires strenuous physical activity, because of his history of high blood pressure, and instead was sentenced to 18 to 36 months. He sued on the grounds that his rights under the Americans with Disabilities Act (ADA), which prohibits a "public entity" from discriminating against a "qualified individual with a disability" on account of that disability. The suit was initially dismissed on the grounds that the ADA does not apply to prisoners, but was upheld on appeal. Thirty-three states joined Pennsylvania in arguing to the U. S. Supreme Court that accommodating inmates' disabilities "simply does not always work in a prison setting," and that extending the law to inmates would impose unnecessary burden by forcing prisons to provide services such as wheelchair access, interpreters for deaf inmates, and special education for inmates with learning disabilities. Justice Antonin Scalia wrote for the unanimous court: "prisons fall squarely within the statutory definition of public entity," and therefore must not, by reason of disability, exclude someone from participation or deny benefits of services, programs, or activities of a public entity. (Pennsylvania Department of Corrections, et al., v. Ronald R. Yeskey, No. 97-634 118 S.Ct. 1952 (June 15, 1998); Title II of the ADA: 42 U. S. C. § 12132.

While this case dealt with a state penal system, it clearly applies the ADA to the system of services that make up the Juvenile Justice System. Thus, from the time the law enforcement officer takes a youth with a disability into custody to the final discharge from the system, the youth has a right to accommodation for any disability. Accommodations for disability must both follow the law and help improve outcomes for youth.

Persisting Shortfalls in the Juvenile Justice System's Response to Youth with Disabilities

Juvenile justice professionals, educators and child disability advocates have long demanded that, in compliance with the ADA and IDEA, the needs of youth with cognitive and/or behavioral disabilities in the juvenile justice system be met. The Appellate Division, First Judicial Department, Supreme Court of the State of New York, for example, published materials on the representation of children with dyslexia and other learning disabilities in the Family Court (Cohen, Lopatto, & Neely, 1990). Rouse (1997) observed that "Individuals with ADHD, who come into the Juvenile Justice System, can go further, faster into the system than children without ADHD" (1997, p. 1). Rouse's observations were confirmed and extended to children and youth with learning disabilities, emotional disturbance, and retardation by a July 1999 focus group with correctional educators from across the Nation (Osher, 1999). The Office of Juvenile Justice and Delinquency Prevention identified similar issues in a 1994 Juvenile Justice Bulletin that called for "full compliance with Federal and State" special education law

and training correctional staff to "meet the mandates of the American's with Disabilities Act" (Gemignani, 1994).

Disability advocates also have pointed to the importance of addressing the connection between cognitive and/or behavioral disabilities and the juvenile justice system. The Parent Network of Western New York, for example, observed that "people who have brain damage are not able to pay attention or focus their thoughts for any length of time. They may appear cocky, disinterested or defiant," while some persons with cognitive disabilities may "be particularly suceptive to authority figures and will seek approval of those individuals even when it requires giving an incorrect answer" (Parents Helping Parents, 1993, p. 1). Similarly, the cover page of a special issue on Learning Disabilities and Juvenile Justice by the Learning Disabilities Association of California included handcuffs and the statement: "by the time you find out your child is dyslexic, he could be starting his first sentence." Also, in a special issue on Juvenile Justice, the Federation of Families for Children's Mental Health's *Claming Children*, families and practitioners identified that the needs of juveniles with mental health concerns were not being met. Family member Jane Adams, Executive Director of Kansas' Keys for Networking (as well as a former correctional educator) described the challenge this way: "with mental health, the juvenile justice system is almost 20 years behind most state and community health systems of care." (Adams, June 1996, p. 3). The failure to address disabilities can have dire consequences. "In some cases," the President of the National Mental Health Association and a colleague observed, "abusive treatment of these children results from their being emotionally disturbed. Staffs in juvenile facilities fail to recognize, and in fact punish, them for symptoms of their disorders" (Faenza & Siegfried, 1998, p. 3).

By responding to the needs of children and youth with disabilities, the juvenile justice system also can begin to address two other pressing matters: substance abuse and the disproportionate arrest and confinement of children and youth of color. Substance abuse often co-occurs with cognitive and/or behavioral disorders. The disorders themselves place children and youth at risk for substance abuse, and the substance abuse, itself, often exacerbates the impact of the disability (Lexcen & Redding, 1999; Prescott, 1998; DeMilio, 1989). Similarly, the failure to respond to disabilities appropriately contributes to "the disparate treatment of minorities in America's juvenile justice systems" (Hsia & Hamparian, 1998, p.1). For example, African-American children with emotional disturbance are less likely to receive counseling and other supports and are more likely to be placed in restrictive settings than their white peers (U.S. Department of Education, 1998).

Background: Federal Efforts Addressing Gaps in the Care of Youth with Disabilities in the Juvenile Justice System

The Coordinating Council on Juvenile Justice and Delinquency Prevention, an independent body within the Executive branch of the Federal government, was established by the Juvenile Justice and Delinquency Prevention Act. The main function of the Coordinating Council is to coordinate all Federal juvenile delinquency prevention programs; all Federal programs and activities that detain or care for unaccompanied juveniles; and all Federal programs relating to missing and exploited children. The Council is chaired by the Attorney General and meets quarterly. The sidebar titled Responsibilities of the Coordinating Council on Juvenile Justice and Delinquency Prevention describes the duties of the Coordinating Council.

Responsibilities of the Coordinating Council on Juvenile Justice and Delinquency Prevention

- *Coordinate all Federal juvenile delinquency programs, programs and activities that detain or care for unaccompanied juveniles, and programs relating to missing and exploited children.*
- *Examine how programs can be coordinated among Federal, state, and local governments to better serve at-risk youth.*

- *Make annual recommendations to the Congress with respect to "coordination of overall policy and development of objectives and priorities for all Federal programs and activities that detain or care for unaccompanied juveniles."*
- *Review the programs and practices of Federal agencies and report on the degree to which Federal agency funds are used for purposes consistent with the requirements of the Juvenile Justice and Delinquency Prevention Act.*
- *Review and make recommendations with respect to joint funding proposals undertaken between the Office of Juvenile Justice and Delinquency Prevention and any agency represented on the Council.*
- *Review the reasons why Federal agencies take juveniles into custody and make recommendations to improve Federal practices and facilities for holding juveniles in custody (OJJDP, 1995).*

Youth/System Experts Evaluate Needs

In March 1997, The Center for Effective Collaboration and Practice at the American Institutes for Research facilitated a focus group of experts sponsored by the Office of Juvenile Justice and Delinquency Prevention, the National Institute for Literacy, the National Recreation and Park Association, the U.S. Department of Education's Office of Special Education and Rehabilitative Services and the Office of Vocational and Adult Education. The purposes of this meeting were twofold: (1) to discuss and analyze the relationship between learning and other disabilities (referred to in this monograph series as children with cognitive and/or behavioral disabilities) and participation in the juvenile justice system, and (2) to make recommendations to the Coordinating Council on Juvenile Justice and Delinquency Prevention concerning the link between these disabilities, juvenile delinquency, and the juvenile justice system. During this meeting, experts from state and local governments, law enforcement, recreation, universities, community and educational groups, juvenile courts, and correctional facilities developed a framework for understanding the relationships between these disabilities and juvenile justice outcomes. Their conclusion: *that the inability of community institutions (including the components of the juvenile justice system) to respond to cognitive and behavioral disabilities contributed to higher arrest rates for youth with disabilities as well as to more restrictive placements, longer placements, and higher recidivism rates. Specifically, the consensus was that in the case of youth with cognitive and/or behavioral disabilities:*

- The juvenile justice system has not responded to nor does it recognize effectively or consistently the[ir] needs;
- Many issues are interconnected, beginning with the lack of early intervention (as with the case of fetal alcohol syndrome) and including early school failure and leaving school, to the inability of the system to respond to these youth as they move toward dangerous behavior. The lack of aftercare is also critical;
- A more restrictive political climate will make treatment of this population more difficult. [These] youth routinely serve their full jail terms due to poor behavior;
- Rates of recidivism are high .when issues contributing to their involvement in the juvenile justice system go unaddressed;
- The connection between [these] youth..and the professionals serving them is often weak. The difficulty these youth have in learning and in controlling impulse, combined with the often inappropriate responses of the professionals interacting with them, frequently leads to dismal results;
- The juvenile justice system must take an active role in intervening on behalf of these youth. For example, youth with conduct disorders who are in custody should not be placed in solitary confinement or left with idle time;
- Both systemic and individual interventions are necessary.
- Both academic and social education is critical;
- Universal access to recreation programs should be the norm; and

- Intervention must be linked to prevention, which begins with preschoolers (Coordinating Council, 1997, pp. 8-11)

The expert focus group concluded that "a revitalized interagency effort, initiated by the Coordinating Council, was urgently needed to reverse the tide of children who are failing in school, engaging in delinquency and violence, and increasingly spending the final years of their youth incarcerated" (Office of Juvenile Justice and Delinquency Prevention, 1997). The group suggested that there should be two major foci for these efforts:

- Prevention of delinquency and subsequent incarceration of youth with disabilities is a priority. These efforts should include early assessment and intervention activities that are coordinated across school, police, court, probationary, and other community-based services.
- Prevention of recidivism also is a priority. These efforts should include appropriate, specially designed instruction services that address the individual needs of youth with disabilities who are incarcerated.

Subsequently, the Coordinating Council on Juvenile Justice met and endorsed the recommendations of the Focus Group.

Directions for Policy

In October 1998, Project Forum of the National Association of State Directors of Special Education convened a policy forum for the U.S. Department of Education's Office of Special Education Programs in conjunction with the U.S. Department of Justices' Office of Juvenile Justice and Delinquency Prevention. Similar to the previous meeting, the purpose of this policy forum was to help determine the Federal government's role in achieving better educational results for youth with disabilities involved with or at risk of involvement in the juvenile justice system. The experts at the policy forum identified eleven issues:

1. There is a lack of compliance with the following legislative mandates in the juvenile justice system: the Individuals with Disabilities Education Act (IDEA), the Americans with Disabilities Act (ADA), and Section 504 of the Rehabilitation Act of 1973.
2. There is a need for increased awareness and training for workers in the juvenile justice system (e.g., judges, probation officers, public defenders), educational system (e.g., teachers and other educators in the public schools and correctional facilities), and mental health system regarding education of youth with disabilities in the juvenile justice system.
3. Research is needed to identify best practices and programs for preventing delinquency, serving youth with disabilities in the juvenile justice programs, and reducing recidivism.
4. There is an over-representation of children and youth of color in the juvenile justice system. This generates concern about differential treatment, the adequacy of information about cultural factors, and the understanding and valuing of differences.
5. We must provide a seamless, consistent, coordinated, and appropriate system of services for children and youth with disabilities across educational, juvenile justice, and other agencies to ensure a smooth transition through the continuum.
6. There is a need to disseminate what is currently known about best practices and programs, as well as what is known about what is **not** effective, in order to facilitate the implementation of best practices.
7. There is a need for more prevention and early intervention efforts to decrease the numbers of children and youth who become involved in the juvenile justice system.
8. There is a need for early and ongoing parent and family involvement in juvenile justice programs.
9. Within the juvenile justice system, there is inadequate coordination between the educational and residential/institutional programs.
10. There is a need to link educational services for youth with disabilities in juvenile justice programs with the larger issues of educational and institutional reform in order for meaningful change to occur.
11. There is a need for ongoing infrastructure support for teachers and other personnel in the juvenile justice system (Project FORUM, 1999).

Since these two meetings and the Coordinating Council's action, several initiatives have begun to address the issues identified by the 1997 Focus Group and the 1999 Policy Forum. For example, the U.S. Department of Education's Office of Special Education Programs, in collaboration with the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention, has funded the National Center on Education, Juvenile Justice and Disability (EDJJ). EDJJ is a collaborative effort involving faculty and staff from the University of Maryland, the University of Kentucky, Arizona State University, the Center for Effective Collaboration and Practice at the American Institutes for Research in Washington, DC, and the PACER parent advocacy center in Minneapolis, Minnesota.

The research, training and technical assistance activities of EDJJ involve school and community-based prevention activities, education programs in juvenile correctional settings, and transition activities as youth leave juvenile corrections and reenter their communities. Through regional meetings, technical assistance, research and evaluation activities, and publication and dissemination, EDJJ is well-positioned to help change the perceptions and understandings about youth with disabilities in communities and in the juvenile justice system. Further, through a network of practitioners, administrators, family members, and policy makers, EDJJ helps shape more effective and appropriate responses and accommodations for youth with disabilities.

Intra-System Needs Assessment

A second example of the Federal government's efforts to address the issues raised during the expert meeting is the National Survey to Determine Special Education Services for Juvenile Offenders with Disabilities, funded by the U.S. Department of Education's Office of Correctional Education. This project, spearheaded by the American Institutes for Research, and supported by efforts from the National Center on Education, Disability, and Juvenile Justice, will determine and verify the extent to which special education services are provided to incarcerated youth with disabilities.

In 1985, Rutherford, Nelson, and Wolford conducted a national survey of the state departments of special education and correctional education to determine the need for, and provision of, special education services to offenders with disabilities. The results of that survey suggested that, although services offered in most states varied widely, not all offenders with disabilities were receiving the special education due to them. In the years since the first national survey was conducted, the number of juvenile and youthful offenders who are incarcerated has increased markedly. In many states that provide special education services to these youth, the percentage of offenders with disabilities has increased as well.

Recently, a national survey revealed data that validates the findings of Rutherford and his colleagues. The National Study to Determine Special Education Services for Juvenile Offenders, conducted by the Center for Effective Collaboration and Practice at the American Institutes for Research in collaboration with the National Center on Education, Disability and Juvenile Justice ant the University of Maryland reveals the educational plight of children and youth with disabilities in juvenile detention, and state juvenile and adult correctional facilities (Quinn, Rutherford, Wolford, Leone, Nelson, Poirier, & Osher, in progress). This survey was sent out to the entire population (547) of secure state, local, and county Juvenile Detention facilities; entire population (91) of corrections systems, and the entire population (51) of State Departments of Education, Office of Special Education in the United States.

The results indicate that 45.2% of the total number of youth detained or incarcerated was reported to have a disability. This finding is particularly interesting given that the U.S. Department of Education figures show that for the 1998-1999 school year (the most recent data available) the percentage of children and youth in the general population with disabilities was only 8.82% (2000).

Local detention facilities reported that of the juveniles eligible for special education, 42.09% had a primary disability diagnosis of specific learning disability and 41.39% were diagnosed as having emotional disturbance. State correctional systems reported similar identification rates. Just over 45% of youth with disabilities were reported to have specific learning disabilities, and just under 45% were identified as emotionally disturbed. Although specific learning disability is a high incidence disability (approximately 51% of all children and youth ages 6-21 with a disability are categorized as having a specific learning disability), the incidence of emotional disturbance in the general school-age population is much lower at only 8% of those with disabilities (U.S. Department of Education, 2000).

Sharing Information and Expertise

This monograph series provides a third example of the Federal government's effort to address issues concerning youth with disabilities in the juvenile justice system. The Office of Juvenile Justice and Delinquency Prevention, the National Institute for Literacy, the National Recreation and Parks Association, the U.S. Department of Education, Office of Special Education and Rehabilitative Services and the Office of Vocational and Adult Education, conceptualized this series to address issues identified by the 1997 focus group.

About This Introduction to the Monograph Series

This introductory volume is divided into four major sections. The first section provides a discussion of the importance of prevention and early intervention as a means of diverting youth with disabilities from entering the justice system. Second, we discuss the various cognitive, behavioral, and emotional disabilities that put youth at greater risk for becoming involved in the juvenile justice system and make their experiences there more complex. Third, we show how disabilities might be addressed as a youth makes his or her way through the juvenile justice system. The last section provides a brief description of the contents of each of the other six monographs in this series. We hope that this series will help to raise awareness of the important issues surrounding youth with disabilities who are involved or at risk for involvement in the justice system and will serve as a springboard for improved practices.

Prevention as a Means of Diverting Youth with Disabilities from Entering the Justice System

In 1997, the most recent year for which complete statistics are available, over 2.8 million juvenile arrests occurred. The majority of these cases do not reflect chronic problems with violations of the law. However, with every arrest, there is increased likelihood that a youth will get into trouble again. A small minority of persistently offending youths account for the majority of juvenile arrests, and many of these individuals will later become adult criminals (Snyder & Sickmund, 1999). Cohen (1998) estimates that the cost to society (victims, police, courts, and corrections) of a single delinquent career is $1.0 to 1.3 million. Regarding the four percent of youths who are considered to be both chronic and violent offenders (Snyder, 1998), and assuming an overall re-arrest rate of 50% within the year, the cost of today's juvenile delinquents is between $76 and 98 *billion*. A more balanced approach to youth interventions, one that focuses on prevention and rehabilitation over repeated sanctions, can maximize the safety and well-being of the public while also minimizing the high costs of punishment (Eddy & Gribskov, 1998).

To be most effective, prevention efforts must focus on several different levels of need. Researchers have applied the traditional three-stage public health model of prevention (universal, selective, and indicated) into approaches for youth with disabilities who are at-risk for involvement in the juvenile justice system (Quinn et al., 1998; Walker et al., 1996). They describe a three-tiered approach to the prevention of problem behavior.

The first tier includes "universal prevention" efforts directed at everyone in a school or community. These efforts include primary interventions such as providing a structured environment with clear behavioral expectations and positive consequences for appropriate behavior. The goal of primary prevention is to avert the initial acquisition of problem behaviors. Universal prevention can reduce the behaviors that place children and youth at risk for involvement in the Juvenile Justice System. For example, it is estimated that school-wide interventions can usually reduce problem behavior for 80 percent of students (Walker et al., 1996). Similarly, community interventions that target those factors that place youth at risk and strengthen those factors that protect youth, can strengthen the youth's bond to his community, help in the development of clear and consistent standards for behavior, and teach children and youth the skills they need to be able to live up to those standards. This approach has been shown to lower costs for intervention and treatment (Catalano, Arthur, Hawkins, Berglund, & Olson, 1998).

At the next level are "selective prevention" efforts. These efforts are directed at youth who are considered at-risk for involvement in the juvenile justice system because of factors such as poverty, high neighborhood violence, family disruption, disability, substance abuse, or poor school performance. Some of these interventions are carried out in small groups. Programs that teach youth social problem-solving skills and

conflict resolution, or after-school therapeutic recreation programs, are examples of these selected, early interventions. Others are individualized, for example, effective special education programs can reduce the school drop-out rate of youth with emotional disturbance, which is over 55 percent (U.S. Department of Education, 1994). This, in turn, is likely to reduce the arrest rate of these youth (73% of youth with emotional disturbance who drop out of school are arrested within three to five years of leaving school [U.S. Department of Education, 1994]). The goal of secondary prevention is to quickly remediate problems while they are still emerging, and to strengthen the impact of protective factors (close relationships with prosocial adults, school achievement, etc.) that might avert subsequent juvenile delinquency.

At the third or "indicated prevention" level, efforts should be individualized and intensive. The goal at this level is to prevent youth who are beginning to experience behavior problems from becoming more severely involved or from recidivating. Services at this level must be collaborative and provide intensive individualized services and supports to meet the needs of the youth and, in many cases, their families as well. Wraparound Milwaukee, a collaboration project between The County Mental Health Division, Child Welfare, and Juvenile Justice, funded by the Center for Mental Health Services Comprehensive Services for Children and Their Families Program, provides an example. This program employed strengths-based, coordinated individualized planning and services to reduce out-of-home placement, costs of services (from $6,000 per month to a little over $3,200 per month), and recidivism, and it improved clinical outcomes for almost 700 youth, 65 percent of whom had committed a delinquent act and were referred to the program by the Milwaukee County Juvenile Court (Kamradt & Meyers, 1999). Wraparound Milwaukee employed such services as care coordination, a mobile crisis team, in-home therapy, family therapy, alcohol and substance abuse counseling, mentoring, respite care, and independent living support to address the needs of these children and youth (Kamradt & Meyers, 1999).

Wraparound in Action: Example

Mark is a 15½-year-old referred to Wraparound Milwaukee in March of 1999 for 1st degree sexual assault of a child. Mark had been originally recommend for transfer to the Department of Corrections for placement in a State juvenile corrections facility. That order was 'stayed' and he was ordered by Children's Court into Wraparound. Mark and his family had strengths including good motivation to accept help, an interest in school and sports, a good sense of humor and an ability to make friends.

The comprehensive range of services Mark received covered many aspects of his life domains. He was enrolled in and successfully completed a special outpatient treatment program for sexual offenders. He was matched with a mentor who got him involved in an after school-recreation program and doubled as a tutor to help him with schoolwork. He and his family were involved in family counseling which has made them a stronger family unit.

Mark has committed no new delinquencies and is doing well at home and in the community.

Joseph, age 16, was referred to Wraparound after multiple delinquencies such as assault, theft, breaking and entering homes, and frequently ran away from home. He had been abandoned as a child and therefore demonstrated poor attachment to adults. At the time of referral to Wraparound he was living on the streets of Milwaukee, finding places to sleep where and when he could.

Joseph also was a quiet, creative child, with a good sense of humor. He was courteous, bright and had good communication skills. After a short 60-day residential treatment placement, he was moved into a group home. He too benefited from being matched with a mentor and a job coach. The job coach worked on skills to help him find a job. His Child and Family Team included the mentor, his brothers, group home staff, and the job coach from the employment agency.

Joseph has not committed another delinquent act in a year and is slated to transition from Wraparound Milwaukee next month. He now has a job working for the City's largest newspaper.

Latasha, 17, had a history of running away and was very street wise at time of referral. Her delinquencies included party to a crime, a serious assault of another child and several counts of criminal damage to property.

At time of enrollment in Wraparound, Latasha was languishing in a residential treatment center. She was bonded with her mother and sister but neither could care for her. Her mother has a serious drug problem and her sister was unemployed with no way to support Latasha. The Wraparound Care Coordinator and her family addressed the mother's needs by involving her in a drug rehabilitation facility called META House. Her sister was referred to an employment agency that helped her find a job so she could be a placement resource for Latasha. Additionally, Wraparound secured some in-home therapy for Latasha and a job coach.

Latasha now is attending school regularly and has an after-school job at a restaurant. She too has had no new delinquencies in over 1½ years in Wraparound.

In all three of these examples, the care coordinator identified and utilized the child's strengths and those of the family in developing a plan. The Child and Family Team guided the planning process rather than a professional. Services were determined based on the needs and strengths identified by the child and family.

A comprehensive array of services was provided to each child to address multiple life domains (e.g., psychological needs, living situation, education, vocational, legal, etc.) Services were highly individualized to that child's needs. Finally, services were provided mainly in the community rather than in institutional settings (Kamradt & Meyers, 1999).

Finally, all prevention efforts also should focus on the strengths of the youth and his or her family. An example of a successful program, which has employed strengths-based individualized planning and care to reduce recidivism, is the Safety Surveillance Network, which is run by the Georgia Parent Support Network. This program provides a "holistic, family-focused, empowerment-based program" that helps adjudicated juvenile sexual offenders to participate in outpatient treatment and to live at home with community safeguards. The Network employs, individualized planning that involves all stakeholders and develops a support plan that provides for appropriate treatment and therapy, continuous supervision, crisis intervention, and progression toward independence. While 24-hour-a-day monitoring is an essential component, the "most important of these safeguards is a 'network' of family members, friends, teachers, coaches, and other community members or professionals who are committed to the success of the child" (Smith & Huckeba, 1999, p. 34).

Early Intervention as a Prevention Tool

Early intervention is also crucial in effectively changing the life pattern of youth involved in the justice system. Along with the severity of crime, age of onset of first offense is a powerful predictor of adult criminality (Snyder & Sickmund, 1999). Thirty percent of juvenile arrests for violent crimes (murder, rape, robbery, and assault) in 1996 involved children aged 14 or younger (Snyder, 1997). Every one of these arrests is an opportunity to respond in a way that will reduce the likelihood of later, repeated problems. Problems with older youth tend to result in interventions that are more restrictive (Howell, 1998), more expensive, and, in general, ineffective (Lipsey, 1995). There are promising interventions, which, particularly when implemented early, can markedly improve outcomes for many of these youth.

The Office of Juvenile Justice and Delinquency Prevention has developed a *Comprehensive Strategy* to address

> *"In most jurisdictions, the juvenile system has little to offer an 11- or 12-year old delinquent youth because they are not yet seen as dangerous... but these delinquents disproportionately include the future violent criminals of their cohort."*
> -- Greenwood, Model, Rydell, & Chiesa, 1996, p. 14.

juvenile justice and delinquency prevention. There are two principal components to this strategy. The first of these is preventing youth from becoming delinquent by focusing prevention programs on at-risk youth. This focus on prevention is justified because the promise of prevention is real (see sidebar: High/Scope Perry Preschool Prevention Program). A scientifically rigorous study conducted by the Rand Corporation (Karoly, 1998) reviewed the social and economic effectiveness of a variety of early intervention programs. Programs providing high-quality day care or preschool-plus-family support significantly reduced criminal activity on the part of participating children in the years following intervention. A program offering home visits by nurses over the first two years of a child's life to high-risk families was found to significantly reduce *mothers'* crime. Savings to the government alone (not including the broader societal savings) of early intervention programs were estimated to outpace costs at a rate of 2 to 1 for a preschool intervention and 4 to 1 for a home visitation program. In general, higher-risk children tend to realize the greatest benefits from early intervention efforts.

High/Scope Perry Preschool Prevention Program

In 1962, the Perry Elementary School in Ypsilanti, Michigan began working with 2-5 year olds in high poverty areas who are considered at high risk for school failure. The program actively involved the children in 10 developmental experiences: creative representation, language and literacy, social relations and personal initiative, movement, music, classification, sequencing, numbers, space, and time. The children are asked questions such as 'What happened? Can you show me?" and 'How did you make that?" rather than merely being drilled on rote academic skills. In addition to the classroom work, the teacher visits each child's home for 90 minutes a week.

This intensive program is cost effective. It is estimated that for every dollar that is spent on the program, $7.16 is returned. In a well-designed and rigorous longitudinal study of the High/Scope program participants and a control group of non-program participants, researchers found significant differences in the outcomes of participants at age 27. These differences include:

- *Arrest rates: 35% of the control group was arrested at least 5 times and an additional 25% of the control group was arrested at least once for dealing drugs. This is compared with a 7% arrest rate for the High/Scope group in each of these two categories.*
- *Education: 54% of the control group completed at least 12 years of school, compared with 71% of the High/Scope group.*
- *Earnings: Only 7% of the control group earned at least $2,000 per month, but 29% of the High/Scope group earned at least this much.*
- *Welfare Participation: 80% of the control group received welfare as an adult, compared with 59% of the High/Scope sample.*

(Henderson & Berla, 1994; Schweinhart, Barnes, & Weikart, 1993; Schweinhart & Weikart, 1993).

Later Intervention

There are promising interventions for at-risk older children as well. Larson and Turner (this series) report these in detail. An economic analysis conducted by Greenwood, Model, Rydell, and Chiesa (1996) compared the costs of various proactive interventions with the costs of California's reactive three-strikes law. The proactive interventions studied included: home visits (birth through age 2) by child-care professionals and provision of four years of day-care; parent training; graduation incentives for poor, minority youth; and monitoring and supervision of delinquent high-school students. Home visits and day-care cost about $23,400 per year; parent training cost $3,000 per family; graduation incentives cost $3,130 per youth per year (for 4 years); and monitoring and supervision was estimated to cost $10,000 per youth. The three-strikes law was estimated to cost $16,000 per serious crime prevented, or $5.5 billion per year if fully implemented (however, due to budgetary constraints and District Attorney discretion in implementation of this law, it has never been fully implemented). Effectiveness rates were reported as follows: home visits reduced crime by 24% (and reduced child abuse by 50%), parent training was reported to reduce crime by 29%, graduation incentives were estimated to reduce juvenile crime by 56%, and the intensive supervision program for delinquents was found to reduce juvenile crime by 8%. It was estimated that if the California three-strikes law were fully implemented it

would only reduce serious adult crimes by 28%. Although the three-strikes law does prevent future crime, it is very expensive, and graduation incentives produce almost the same benefit at about 10% of the cost.

The Importance of Family Involvement

One challenge all prevention programs face is gaining the trust and cooperation of the families involved. In most truly preventive interventions, the children are not yet in trouble, and the family is not necessarily asking for help. They may not want "the man" getting into their business. This may be the case particularly for families of color who have historically been treated unfairly by government or bureaucratic systems and who may be wary of diagnostic labels or of participating in the next "program" with uncertain benefits. It is incumbent upon those practicing prevention to use culturally competent, family-friendly, and community-based initiatives to help families accept the best services available.

One issue in reaching families is timing. When are families most open to intervention? Research shows that points of transition are the most opportune times to reach out to families. Transition points include such events as the birth of a child, a child starting or changing schools, divorce or other family changes, or a child's initial contact with the juvenile justice system. At any and every opportunity, people in helping roles can act to improve the life outcomes of that child and his family, and decrease the likelihood of arrest, adjudication, or recidivism.

Another issue in reaching families is stigma. One way to make preventive services less stigmatizing for families is by focusing on strengths and on building resilience rather than focusing only on problems, "dysfunction," or deficits. (This approach is discussed in more detail in Assessment and Evaluation.) Imagine your son has been arrested and charged with drug possession. What would you rather hear, "Your son is in big trouble – he's probably going to become an addict if you don't do something now," or "Your son is in trouble now, but we would like to support him in choosing a more positive path"?

Assessment and Evaluation

Traditionally, agencies assess children with cognitive and/or behavioral disabilities by using only deficit-oriented assessment tools to identify the child's problems and weaknesses. Researchers argue that this does not give the evaluators and program developers a complete picture of the child and does not provide enough information to develop, implement, and monitor comprehensive intervention plans (Harniss, Epstein, Ryser, & Pearson, 1999). Families and service providers need to know more than just what is wrong with the child; they need to know what is right with him or her as well. This information is believed to be key in developing better Individualized Education Programs and individual service plans (Epstein, in press).

Recently, the use of only deficit-oriented assessment tools also has been called into question by a number of social service and education initiatives such as the U.S. Department of Education's National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (1994), Wraparound approaches (VanDenBerg & Grealish, 1996), and the Child and Adolescent Service System Program (Stroul & Friedman, 1994). These initiatives call for the use of strength-based assessments that will view each child as an "individual who possesses unique strengths and weaknesses" (Harniss et al., 1999, p. 12). Strength-based assessment has been defined as "measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social, and academic development" (Epstein & Sharam, 1998, p.3). It is argued that strength-based assessments in conjunction with the traditional deficit-oriented assessments will yield a more complete picture of the child and will ultimately lead to more accurate, effective, and comprehensive intervention plans.

Strength-based assessments exist that can highlight the resources, supports, competencies, and preferences a child has upon which interventions may be built (see sidebar: A Strength-based Approach to Evaluation).

A Strength-based Approach to Evaluation

The Behavioral and Emotional Rating Scale (BERS; Epstein, & Sharma, 1998) is a 52-item scale assessing various strengths of children ages 5-18. It is divided into 5 subscales (Interpersonal Strengths, Family Involvement, Intrapersonal Strengths, School Functioning, and Affective Strengths) and can be completed by teachers, psychologists, social workers, or parents in as little as 10 minutes. Sample items include:

- *Is self-confident.*
- *Demonstrates a sense of humor.*
- *Enjoys a hobby.*
- *Participates in family activities.*
- *Talks about the positive aspect of life.*
- *Uses appropriate language.*
- *Uses note-taking and listening skills in school.*

A strength-based approach to assessment is one way to enhance protective factors (discussed in the next section), and it is the cornerstone of competent practice. The goal of enhancing protective factors is to moderate the risk factors that are responsible for causing or increasing the likelihood that problems will occur (e.g., poverty, disability, disorganized communities). Protective factors do not remove risk factors, but can help increase the child's resistance to them. For example, protective factors cannot remove children's learning disabilities, but will provide them the supports necessary to be successful in school in spite of their disabilities, and prevent the onset or growth of delinquent behavior.

Protective Factors to Enhance Prevention

Researchers have identified three categories of protective factors: (1) individual, (2) social bonding, and (3) beliefs and standards for behavior (Hawkins, Catallano, & Miller, 1992). Individual protective factors include being a female, being intelligent, and having a positive social orientation and a resilient temperament (Rutter, 1985; Werner & Smith, 1982). Social bonding includes having a strong, supportive, and loving relationship or attachment with your family or other adults (Garmezy, 1985). Finally, healthy beliefs and clear standards include a family and community that value academic achievement and healthy development and object to violence and crime (Brewer, Hawking, Catalano, & Neckerman, 1995). For a discussion of risk and protective factors see Leone, Quinn, and Osher (this series).

Prevention and Sensitivity to the Individual

Prevention works best when it revolves around an ongoing commitment to positive outcomes that involve the youth and the family. School involvement is crucial when children are of school age. Community norms against delinquent behavior need to be built and reinforced. Most of all, any and all prevention programming must be appropriate to the developmental level of the child involved (preschooler, elementary school-age child, or teen, for example) and must be culturally competent. Prevention works when it is implemented in a sensitive, positive way where everyone realizes the benefits.

One theory-based approach to prevention asserts that every individual functions in and must adapt to different "social fields," such as home, school, and the peer group (Kellam, Branch, Agrawal, & Ensminger, 1975; Kellam & Rebok, 1992). Each social field has one or more "natural raters" who make the rules and who can determine whether an individual is adapting well or poorly (parents, teachers, peers, intimate partners, and bosses are examples of natural raters). Over the course of our lives, these social fields change in terms of their salience, becoming more or less important in our overall lives. The heart of the theory is that when we succeed, we are happy, but when we fail to adapt, our psychological well being suffers. Failure in one social field puts us at risk for failure in other domains, and early failure is a risk factor for later failure. Prevention must be specific to a given social field, and any assessment of the effectiveness of that preventive intervention must include that social field's natural raters.

Disabilities of Youth in the Juvenile Justice System

Once a youth has entered the juvenile justice system, in order to produce the best outcomes for that individual and for the public, the needs of that youth must be responded to effectively. Rutherford, Bullis, Anderson, and Griller-Clark (this series) review prevalence rates of youth with emotional, behavioral and learning disabilities in the system. In short, children with cognitive and other disabilities are overrepresented in the juvenile justice system.

Learning Disabilities

The definition of "learning disability" is controversial. Since the term was coined, a battle has been waged over a proper definition. Part of the problem with defining "learning disability" is that no two individuals with learning disabilities necessarily "look" alike. One child with a learning disability may have difficulty in spelling, while another may have difficulty in math. Furthermore, youth with learning disabilities do not necessarily struggle in all academic areas. Having a learning disability is not equivalent to having mental retardation. Children with learning disabilities generally perform in the "normal" range of intelligence, and although they may struggle in one academic area, they may perform as well as any nondisabled youth or even excel in other academic areas. A child with a reading disability may perform at two grade levels below his peers' reading level, but at the same time perform at two grade levels above his peers in math.

Although a child with a learning disability may not, on the surface, appear to experience as many or as significant problems in school as other students, she or he does struggle. No one who has a learning disability "outgrows" it. Having a learning disability is life-long, and a successful adult who has a learning disability has learned to cope with his or her condition, has discovered and built upon his or her strengths, and has shown great perseverance.

Learning disabilities are commonly associated with reading problems; however, they also can be manifested in other difficulties including but not limited to spelling, written expression, and math. Reading problems may relate to understanding the rules involved in putting sounds together to make up words (phonological skills) and visually processing information from letters. Dyslexia is a specific kind of learning disability related to severe reading difficulties. Youth with learning disabilities involving writing may experience great difficulty with spelling, handwriting, and/or composition (writing fluency and strategies – planning, organizing, drafting, and editing). A youth with a learning disability also may have great difficulty holding a conversation. She or he may struggle with the mechanics of spoken language (such as grammar), as well as with meeting social expectations of what one would call comfortable, "normal" discourse. In math, a student with a learning disability may have difficulty with computation and/or problem-solving (choosing the correct strategy). A child with a learning disability may experience visual perceptual problems (e.g., reversing letters, seeing and remembering shapes – putting together a jigsaw puzzle may be particularly difficult for him or her to do), as well as what one would call "coordination" problems (i.e., problems with fine and gross motor skills). Youth with learning disabilities also may have problems with memory. It is not uncommon for a child with a learning disability to forget something she or he just heard or saw, and/or to remember one thing as she or he is attending to something else. Children with learning disabilities often do not use strategies to obtain or retain information the way nondisabled youth do. In many instances, learning disabled youth have great difficulty making plans, organizing their thoughts, and utilizing problem-solving techniques (e.g., improving reading comprehension, what to do if placed in a problematic situation).

In addition to the academic problems described above, children with learning disabilities may also display social and emotional problems. This may be due to their misunderstanding of social cues and misinterpretation of the feelings of others. Learning disabled youth may experience motivational problems, due to their feelings of lacking control over situations. Often, children with learning disabilities feel controlled by others and have little if any sense of control over their own lives. Further, these children are often insecure about acting positively and making correct choices, and do not believe that they adequately solve problems. It is not surprising, then, that youth with learning disabilities often have low self-esteem.

How is it that we can help youth with learning disabilities? From an educational standpoint, children with learning disabilities can benefit from developing and fine-tuning learning and problem-solving strategies, developing self-determination skills, and through Direct Instruction (i.e., a rehearsed, highly structured

instructional model that focuses on repeated and intense drill, practice, and immediate feedback). Some examples of effective instruction models include (but are not limited to) the following:

- Self-instruction – where children talk themselves through problem solving, asking such questions as, "What is the problem?" "What do I need to do to solve this problem?" and follow a series of steps to accomplish a goal, including monitoring progress and ending with the children giving themselves a "pat on the back";
- Scaffold instruction – a master-to-apprentice form of instruction that begins with observing the teacher go through the steps of problem-solving, then having the youth go through the steps under the guidance of the teacher, then having the teacher taper off guidance until the youth can perform the task on his/her own;
- Using mnemonic devices – converting abstract information into more concrete representations (e.g., remembering the word HOMES to help recall the names of the great lakes: Huron, Ontario, Michigan, Erie, and Superior). This is particularly effective when youth are attempting to learn new vocabulary words or concepts with which they are not familiar.

Emotional/Behavioral Disorders and ADD/ADHD

Most people have long regarded problems like anxiety and depression as "emotional" disorders. What researchers are increasingly coming to see is that conduct problems, the kinds of behaviors that can get youth into trouble, are also emotional disorders. The root of these disorders lies in an individual's emotion regulation system. These children find it very difficult to control their emotions and consequently, often have difficulty controlling their behavior.

Conduct problems reflect improper regulation of the anger and anxiety systems. Children with these problems feel anger much too readily (e.g., they may become physically aggressive if someone brushes against them in a hallway) and have learned to suppress anxiety about punishment. Most troubled youth who do not express fear, still experience it. Oddly enough, the experience of fear or anxiety has been found to predict better adult outcomes. One study (Raine, Venables, & Williams, 1995) for example, found that the experience of anxiety (i.e., increased heart rate and palm sweating) in youths, whether or not that anxiety was expressed, was associated with decreased criminality as an adult.

Anxiety by itself can be a debilitating condition. Youth with anxiety problems are so afraid, uneasy, or worried that they are not able to carry out their lives in a normal way. There are several distinct disorders of anxiety. *Specific phobias* are unrealistic and excessive fears of some situation or object. Some truancy may be related to school phobia, which is an irrational fear of going to school (school refusal because of fear of bullies is not strictly irrational, but may also be related to truancy). Youth presenting with *generalized anxiety disorder* may seem tense, fatigued, self-conscious, and may continually seek reassurance. These children may also have stomachaches, headaches, or other physical problems related to their uncontrollable, excessive worrying. *Panic disorder* refers to the persistent concern about, or extensive avoidance of, situations that might bring on panic attacks. Panic attacks are sudden, intense, but usually relatively brief experiences of great fear in which the individual often fears he or she is losing control or dying. Some people have persistent ideas, impulses, or images (obsessions) that are unpleasant and cause anxiety. Those individuals may then engage in repetitive acts (compulsions) that relieve that anxiety but take up so much time or cause such severe distress that *obsessive-compulsive disorder* is diagnosed. Youth with odd habits or rituals, especially if they involve checking, washing, or putting things in a certain order, may have this condition. Finally, youth from violent homes or violent communities may have symptoms of *post-traumatic stress disorder (PTSD)*. This disorder involves persistent re-experiencing of some trauma, often with feelings of guilt about surviving or what had to be done to survive, avoidance of things associated with the event, feeling "numb," and a sense of hyper-alertness. PTSD may be associated with a loss of previously held sustained beliefs, self-destructive or impulsive behavior, hostility, feeling damaged, or social withdrawal.

Mood disorders are also common among youth. Depression is a period of at least two weeks when, for most of the time, a person is sad, irritable, or has lost interest in things that used to be enjoyed. Not caring about things, feeling worthless, or feeling guilty may be signs of depression, especially when combined with

changes in appetite, sleep, physical activity, or sexual interest. Suicide is a complication of depression that cannot be accurately predicted. Therefore, close supervision of depressed youth is always indicated.

Another type of mood disturbance is called mania. Mania involves excessively euphoric, enthusiastic, or irritable mood. It is not uncommon for actively manic individuals to come to the attention of law enforcement authorities, as they may engage in risky, illegal, antisocial, and/or unethical acts in flamboyant ways. Youth with mania often sleep much less without feeling tired, speak or think rapidly, and are easily distracted. Some people alternate between depressed and manic moods in a cycle that is referred to as "bipolar," or "manic-depressive." Treatment of mood disorders typically involves education, psychotherapy, and usually medication.

The role of irritability in both anxiety and depressive disorders is especially important to highlight for youth in juvenile justice contexts. Not all outbursts of anger are signs of "rotten" behavior, and not all behavior is a youth's choice. When people have an emotional disorder such as those described here, they may be confused and upset by their own behavior, and feel helpless to change the way they are acting. This does not mean that they do not seem obnoxious to others – poor social functioning is a diagnostic criterion for emotional disorders. It simply means that many youth who are in trouble could benefit from assessment and appropriate treatment of their emotional problems.

Attention Deficit Hyperactivity Disorder (ADHD) is the behavioral disorder most often co-occurring with delinquency (other than Conduct Disorder, which has significant overlap with delinquency). Children with ADHD present as extremely physically active and fidgety (much more than that individual's cultural norm), impulsive, and inattentive. Whereas conduct problems reflect underlying problems in emotion regulation (as described above), ADHD is currently regarded as a genetically influenced disorder of the brain's behavioral inhibition system. Inhibition is the ability to stop oneself from doing something, and it has important roles in memory, emotion, and speech. Studies over time have demonstrated that children with ADHD are at increased risk for academic problems, antisocial behavior, drug use/abuse, academic dropout, and depression. Whether alone or in combination with other problems, the treatment of choice for ADHD is the combination of accurate diagnosis, counseling about the disorder, medication, and accommodation using behavioral methods, environmental changes, and curriculum adjustments.

> *"From a prevention framework, ADHD can be conceptualized as a vulnerability factor for the development of more severe and chronic psychopathology. Similar to interventions used to treat individuals with chronic diseases such as hypertension and diabetes, intervention efforts with ADHD children should focus on preventing development of debilitating complications."* -- Gerald Rouse August, 1997

Comorbidity

One factor complicating assessment and treatment of youth in trouble is the fact that emotional, behavioral, attention, and cognitive problems do not always occur one-at-a-time. Particularly during childhood and adolescence, comorbidity (the presence of multiple diagnoses) is strikingly common. For example, in a recent review of general population studies, Zoccolillo (1992) indicated that up to 50% of children with conduct problems also had anxiety or mood disorders. For youth with conduct problems, withdrawn behavior tends to be related to physical aggression and problems like stealing or lying, and depressed mood tends to be related to delinquency and substance use (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998). Early onset delinquency is especially likely to be associated with depression. Learning disabilities also occur in about 38% of youth with emotional or behavioral problems (Fessler, Rosenberg, & Rosenberg, 1991).

The reality of comorbidity is especially troubling for those who prefer to compartmentalize youth into specific service programs based upon some diagnostic label. The effort to determine which type of intervention is most appropriate for which kinds of youth may be noble, but it may also be problematic if "typing" is carried too far. The best outcomes are realized when youth receive individualized, culturally competent assessment, and coordinated, family- and community-based services.

Addressing the Invisible Barriers for Children with Disabilities in the Juvenile Justice System

Behavioral characteristics associated with cognitive and other disabilities create problems that are seen in the home as well as in school. When a child or youth later comes in contact with the justice system, these problems become magnified. These children and youth have difficulty behaving appropriately toward law enforcement and other authority figures, and are often unable to understand the consequences of their behavior. Therefore, they are more likely than other children to be taken into custody. Adding to this problem, the behavioral characteristics of a child or youth with disabilities can lead to inappropriate interactions with officers and others in the system. Once in the system, inappropriate testing and assessment of a child's disabilities and needs can occur due to inadequate testing materials or initial perceptions of problematic behavior. Disabilities may be considered irrelevant to the adjudication process once a crime has been committed. Law enforcement officers, lawyers, judges, teachers, and others in the correctional system need higher levels of support in order to understand the specific problems and needs faced by children with learning, cognitive, and behavioral disabilities and to learn effective strategies for intervention.

In order to begin addressing the barriers to effectively meeting the needs of children and youth with cognitive and other disabilities, this section walks though the various stages of a youth's involvement in the justice system, and discusses ways that disabilities can be addressed and accommodated, so that the law is followed and outcomes can be improved.

Custody/Detention

In each state, there is a legal process for deciding when a juvenile should be detained. If it is for a criminal violation, the law enforcement officer who has contact with the youth generally makes the initial decision to detain or release the youth. In making this decision, the officer considers several factors, but the two most important should be the protection of society and the best interests of the youth. If the youth is violent and is not likely to appear for further proceedings, then he or she should be detained. However, if there is no danger to society and there is no reason to believe the youth will not appear for subsequent proceedings, then the youth needs to be released to a parent, guardian, custodian, or other responsible adult (and may have conditions placed on his or her freedom). If the youth is detained, then immediate notice must be given to the parents, guardian, or custodian of the youth. Youth with disabilities are often at risk to be held rather than released. Because of the nature of their disabilities, the youth may say the wrong things, fail to process information appropriately, or make decisions quickly without thinking. A youth with a disability may not understand what the officer is saying, and may not understand the written materials given to him or her to sign.

The assessment process for youth detained by authorities should require that the parent, custodian, or guardian of the youth be questioned regarding any special needs, medications, or other information that would affect a youth in detention. Staff at all facilities should ask questions regarding whether the youth is taking any medications, and whether the youth has any diagnosis that qualifies as a disability under either IDEA or the ADA. When staff become aware that a youth may have a valid disability, then accommodations should be made for participation in any programs, explanation of detention policy, and detention rules. A staff person may need to go over a written set of rules with the youth to make sure the youth is able to comprehend and participate in any programs. Some short-term detention facilities provide for continuation of the youth's educational needs. A policy requiring contact with the youth's school to obtain his individualized educational program (IEP) should also be in place so that those youth who qualify under IDEA may continue with their educational programs.

Initial Appearances

The initial appearance takes place shortly after the youth enters detention. It may be only for another detention hearing, it may be after the petition/charge is formally brought, or for both these reasons. It is recommended that the child have a non-waivable right to effective counsel in all juvenile court cases. The juvenile court will, if the formal petition is on file, explain the constitutional/statutory rights to the juvenile and the juvenile's parent, custodian, or guardian. Accommodations for those juveniles who have a recognized disability are required. This may mean allocating more time for the explanations of rights, requiring a quiet atmosphere, cutting down on possible distractions in the court room, and possibly providing written

explanations of juvenile rights that the youth may take with him for later reference. Once the juvenile judge has explained the youth's rights and made a determination regarding legal counsel, a date is scheduled for the juvenile to plead or admit/deny the petition. At the detention hearing, the juvenile court considers whether further detention is necessary. At this time, legal counsel for the juvenile should present any relevant information that would affect a decision for further detention. If the parent is able to testify that the juvenile does, in fact, have a recognized disability, then the court is alerted that accommodations will need to be made for the juvenile at other hearings. If the child benefits from medications, and the detention center does not have access to those medications, then the court should enter an order providing for the administration of the medications. The court may be petitioned to place the juvenile with a parent or responsible adult who will make sure the juvenile takes the medications as prescribed.

Prosecution Filing Decisions/Diversion

There are many different types of programs across the country through which a youth can voluntarily enter a diversion program and avoid having to go through the formal processes of juvenile proceedings. In some states, the prosecution makes that decision. In other states, an arm of the court may make that decision. All such programs provide that, if the youth meets the requirements of the diversion contract, the charges/petition will not be processed against the juvenile and will not go on the youth's record. The law clearly requires the entity making a decision to divert a youth to make accommodations for any disability, which may influence whether the youth is diverted or not.

Cognitive and Behavioral Disabilities and Trial Issues

Youth have the right to pretrial motions raising issues about the detention and voluntariness of their confessions (*People ex rel. Guggenheim v. Mucci*, 1974; *Rhodes v. State*,1975). The United States Supreme Court, in criminal cases, has held that a defendant is denied their 6th and 14th Amendment rights to present a defense if prohibited from presenting evidence "about the physical and psychological environment in which the confession was obtained" (*Crane v. Kentucky*, 1986). Recently, the Nebraska Supreme Court reversed a first degree murder case on the grounds that the defendant had been prohibited from presenting evidence from a clinical psychologist who had conducted a mental health evaluation of the defendant and who had also reviewed the defendant's confession to the murder. The psychologist was prepared to testify that the defendant suffered from major depression, attention deficit disorder, anxiety disorder, and paranoid personality disorder. The psychologist also was prepared to testify that the defendant, prior to his confession, was incarcerated and was in the throes of methamphetamine withdrawal. The psychologist would have testified that the effects of the withdrawal included severe depression, extreme feelings of hopelessness, difficulty concentrating, and high levels of distress and suggestibility. As a result, the defendant would waiver in his attitudes and beliefs, would process information haphazardly, and would often reach faulty conclusions. The State Supreme Court held that the trial court, in excluding the proffered testimony, did not make a harmless error and reversed the decision (*State v. Buechler*, 1998). This ruling could be applied to a juvenile court in considering the confession or other defense of a juvenile with a disability or combination of disabilities.

Adjudication Hearing/Trial

Should the juvenile not wish to plead/admit the facts in a petition, then a trial must be held. Should the juvenile admit/plead to the allegations, then the court must be careful to go though a question-and-answer process to make sure the juvenile knows what he is doing and is voluntarily admitting/pleading to the allegations.

When trial is held, the Court must ensure that all procedures necessary to protect the juvenile's rights are followed and that a record is made of the proceedings in case there is an appeal later. During the trial, the court, if so informed, must make accommodations for juveniles with a demonstrated disability. This could be as simple as providing an interpreter for a deaf juvenile or making more subtle accommodations for a juvenile diagnosed with ADHD. Because the Federal government considers ADHD a disability, if the disorder limits a major life activity, then individual's appropriately diagnosed with ADHD are entitled to reasonable accommodations in the courtroom, just as they are in the classroom or workplace (*Aviles v. Bowen*, 1989).

Courtroom accommodations might include careful repetition of important information, additional time to think in response to questions, and non-confrontational communication.

Post Adjudication Evaluations

Every state has an assessment process after adjudication in which an entity examines various aspects of the juvenile's actions, his past, influences to which the juvenile may have been subjected, restitution to any victims, and safety of the public in formulating an appropriate disposition/sentence. A juvenile court will have an array of dispositions, which may range from leaving a juvenile in the home to commitment to a locked facility. The modern juvenile court is interested in protecting society, restitution to the victim, and individual rehabilitation. The evaluation, therefore, should look not only at the concerns of public security and restitution to the victim and society, but also determine which program or programs will work best to make the juvenile a productive part of society.

The juvenile court's probation department is generally the place where the evaluation/pre-disposition report begins. Again, as in the detention portion of the system, an assessment occurs to examine the juvenile's past and present situation, and to make future predictions for him or her. When the evaluator is gathering information, parents/custodians should be asked if the juvenile is under any treatment for mental and emotional problems, taking any medications, or has an IEP in school. If the probation department has expertise in the areas of learning and other disabilities, then some prescreening should be available for determining the need for more in-depth evaluations. For less-specialized offices, training in preliminary screening should be required with a final determination to be made by medical or mental health professionals. The court should, either by statute or by court order, have the authority to conduct medical and psychological testing either at parental or government expense. Because some disorders such as ADHD are highly responsive to drugs, it is imperative to use trained physicians in the local or nearby communities for some of the diagnosis and treatment processes.

Dispositions/Sentences

The juvenile courts should use a continuum of program options in the provision of services for delinquent children and their families. Priority should be given to providing sanctions and services for potentially or already serious, violent, and chronic juvenile offenders as early as possible in the youth's life. However, services for mentally ill, mentally retarded, and other youths with disabilities are severely lacking in most juvenile justice and mental health systems. It would be beneficial to both the juvenile system and the juveniles if disposition orders required that juveniles be given information to help them understand their disability and on strategies to manage their disability.

Where appropriate, medications can help a juvenile manage their disability. Medications should be prescribed and monitored by physicians familiar with the comprehensive treatment of children and youth. A program that does drug screening should be modified to screen not only for illegal drugs, but also to ensure the proper medications are being taken.

The juvenile justice system should work hand in hand with the various schools in which their juveniles are placed. A checklist for the probation officer should consider whether the child is a special education student and, if so, whether there is an Individualized Education Program (IEP) for the juvenile. In those areas where the probation department or court services are able to have this information from the school for the disposition report, the officer should look at how the court disposition can enhance the IEP through appropriate programs that allow the juvenile to do well in his or her program at school. Court-ordered tutoring and study halls may be helpful to juveniles who are having problems in school and need the extra incentive and support.

In some cases, the court will have no choice but to remove a juvenile from his home and possibly the community, either for the welfare of the juvenile, the safety of the community, or both. When this choice has to be made, a judge must require the court to have options for appropriate placement of the juvenile with a disability. When aware of a juvenile with a disability, the juvenile system ought to look for a placement that can facilitate the rehabilitation of the youth. This should include, for some disabled juveniles, facilities that give medications when appropriate and provide training programs to enable their staff to develop a clear understanding of the symptomatology of disorders such as ADHD, depression, and anxiety disorders. Courts should communicate that they expect the facilities in which they place juveniles to be qualified and able to

handle special education problems and juveniles with these types of disabilities (Bolson, Quinn, & Nelson, in press).

Revocations/Further Dispositions

It is a truism that there is not a single juvenile judge or probation officer who hasn't had a juvenile, despite the very best plan, do things that are in violation of their probation and/or court order. Whether it is committing another law violation, failing to complete community service work, violating curfew, associating with persons he/she is not supposed to, or skipping or flunking school, juveniles often test the juvenile justice system. When a probation officer or institutional worker finds that juveniles are not living up to their part of the plan, they must decide if it is serious enough to warrant further juvenile court intervention.

Personnel trained to understand behavioral and cognitive disabilities may examine whether a disability played a role in the transgression. If so, personnel may ask questions such as: Was it because a juvenile quit taking his medications, or was the supervision that was to be provided by the family or others missing? If the juvenile is in an institution, has the institution made accommodations in its programs for the disabled child? If the institution does not make accommodations, then it may be prohibited from taking action against the juvenile, if the juvenile's actions were the result of the disability.

If there is a violation, then the probation department or the institution, if the juvenile has been placed, should act in a timely matter, because sanctions occurring closer to the time of the action can have a more powerful (and beneficial) effect on the youth. Such sanctions as less free time, loss of a privilege, or not being allowed to associate with individuals who facilitate inappropriate decisions are needed.

Training of Judges, Lawyers, and Others

Juvenile court judges, family court judges, and judges exercising juvenile court jurisdiction need training in more than the traditional aspects of the law. It continues to be important for a judge to know due process and the rules of evidence, as in any court. However, judges who fail to understand the developmental and psychological needs of youth who have disabilities, and how these needs affect their actions and reactions in the system, are failing not only the law but the youth they are charged with helping.

A judge needs to set the standard by making time for education regarding the needs of juveniles with disabilities and requiring staff to engage in continuing education on the latest techniques for accommodating various disabilities affecting youth. Juvenile courts can and should require training of guardians ad litum and legal counsel who represent them and the juvenile. The judge of a juvenile court should never consider appointing a legal counsel who has not been trained in representing juveniles and juveniles with disabilities.

A Summary of the Monographs

The monographs in this series address the key issues surrounding the topic of youth with disabilities in the juvenile justice system, or youth who are at risk of coming into contact with the juvenile justice system. The goal of these monographs is to improve services to these children. It is our hope that the information in these bulletins will be useful in achieving the long-term goal of creating a comprehensive juvenile justice system that is sensitive to the unique needs of youth with disabilities.

In their essay, ***Youth with Disabilities in the Correctional System: Prevalence Rates and Identification Issues***, Robert Rutherford., Michael Bullis, Cindy Wheeler Anderson, and Heather Griller-Clark review current data on disabilities requiring special education and related supports. The authors find that youth with cognitive, behavioral, and emotional disabilities are entering the correctional system at rates four to fives time greater than their representation in the general population. Analyzing disability rates also is discussed as a complex task due to inconsistencies in identifying and defining disabilities. For example, individuals identified as having a disability by one agency (e.g., children's mental health agencies) may not be recognized as disabled by the correctional facility. Moreover, research on prevalence rates may use different definitions, making it difficult to compare findings across studies.

Rutherford et al. (this series) emphasize that awareness of issues surrounding disability identification are insufficient for establishing an infrastructure for consistent provision of necessary services. Knowledge of prevalence rates and identification issues is viewed as a starting point for effective services and support. The

information provided in this monograph is useful for practitioners involved in system-level administrative planning, personnel recruitment, and the development of intervention programs for children and youth with disabilities in the correctional system.

Katherine A. Larson and K. David Turner identify and describe best practices for reducing delinquency and preventing recidivism in their essay, ***Best Practices for Serving Court-Involved Youth with Cognitive and Other Disabilities.*** Larson and Turner also describe a small number of model programs directed toward court-involved juveniles with disabilities. Because of the connection between disability and delinquency, it is likely that a significant proportion of court-involved, disabled youth can be expected to manifest social skill deficits and thus be difficult to manage. However, interventions that are skill-based, use positive discipline, teach self-control, social cognitive skills and problem solving, and which involve the youth's family are shown to reduce recidivism as well as increase a youth's prosocial behavior, commitment to school, and trust in working with systems. Approaches that address the needs of youth in all of his or her environments have a greater chance for success than those directed exclusively at a youth's behavior in school settings.

Larson and Turner describe eight types of effective practices for working with court involved youth. These research-based practices, used in combination, can help reduce delinquency and recidivism. These practices include: individual juvenile planning; skill-based interventions (including counseling, social-skills training, academic and vocational interventions, and life skills/multimodal approaches); medical interventions (including medication and substance abuse treatment); behavioral systems; family involvement; the use of individualized transition planning (including a transition plan and a system of care and wrap-around planning and supports); effective staffing; and the ongoing assessment of program effectiveness.

Current Education Practice for Youth with Learning and Other Disabilities, by Kenneth Howell and Bruce Wolford, describes children and youth currently placed in the juvenile justice system, the educational services provided to them, and the quality of those services. In addition, the authors provide specific recommendations for improving services to children and youth with disabilities. To provide a complete overview of current conditions and practices, the authors examined correctional system monitoring reports, materials from enforcement actions taken against correctional agencies, and reports from interviews conducted with correctional educators, administrators, and security staff. The authors found that there was a frequent lack of understanding by correctional system practitioners of appropriate educational materials and supports for children and youth with disabilities. This finding is underscored by the many violations found in Individual Education Programs (IEPs) prepared for children and youth placed in correctional settings. Howell and Wolford recommend better assessment, instructional, and curricular practices in support of children and youth with disabilities, and also identify five major barriers to providing effective special education services in correctional settings. Improvements in system leadership and financial support at the state level are emphasized as necessary for overcoming existing barriers.

Building strengths and protective factors are the issues raised in Lorraine Peniston and David Howard's ***The Role of Recreation in Preventing Juvenile Delinquency and Recidivism Among Youth with Disabilities***. Research suggests that youth with disabilities involved in, or at risk for involvement in, the juvenile justice system benefit from community parks and recreation programs. Individuals with and without disabilities can profit in various ways from taking part in recreation activities, and that integrating people with and without disabilities in recreation settings has benefits for both groups. Parks and recreation programs have the potential to prevent children from getting into trouble, while providing them with enriching activities that contribute to their development. Peniston and Howard examine community efforts to provide recreation services to at-risk youth. Quantitative and qualitative data from these programs show improvement in academic performance, decreased involvement with the juvenile justice system, better communication with families, a more positive outlook on life, and greater self-confidence. In addition to recreation programs for at-risk youth, the authors describe therapeutic recreation programs specifically designed to address the more intensive needs of youth with disabilities. The combination of structured and unstructured recreation activities that are used in therapeutic recreation appear to be a viable treatment intervention for children with disabilities.

Carl Smith, Joan Esposito, and Soleil Gregg in *Advocating For Children with Cognitive Disabilities in the Juvenile Justice System* discuss the crucial role of advocacy for youth with disabilities. Smith et al. discuss

the challenges involved in helping professionals, family members, and the youth themselves understand the connection between disabilities and problematic behavior. This monograph describes the multiple barriers that often hamper youth with cognitive and other disabilities from receiving appropriate interventions that might help them avoid contact with the justice system or teach them new patterns of behavior after they have been incarcerated.

Smith et al. suggest eight principles to guide advocacy for this group of youth. These principles are designed to help reduce the risk of initial entry into the juvenile justice system, and to increase and improve services for those youth who are already incarcerated, in order to reduce the risk of recidivism. These strategies include advocating for improvements in research, public education and working with the media; individual case advocacy for youth and their families; coalition-building among concerned families, advocates, and professionals; legislative or administrative advocacy; and litigation. Finally, Smith et al. describe a model program that provides individual case advocacy to youth in the juvenile justice system that have undiagnosed cognitive or emotional disorders.

Peter Leone, Mary Magee Quinn, and David Osher explain the role of collaboration among education, mental health, child welfare, recreation and youth development, law enforcement, disability organizations, and juvenile justice in improving practices and services for youth in the juvenile justice system. Their monograph, ***Collaboration with the Juvenile Justice System and Youth Serving Agencies: Improving Prevention, Providing More Efficient Services, and Reducing Recidivism for Youth with Disabilities*** begins with a discussion of the categorical, fragmented, and uncoordinated services that currently exist, and describes collaboration as a viable option for improving these services. The authors suggest strategies for implementing positive and proactive collaborative approaches to preventing delinquency through a three-tiered approach that includes primary, secondary, and tertiary prevention activities. These activities serve to decrease the risk factors and increase the protective factors that can "predetermine" negative outcomes for many youth at risk for involvement in the juvenile justice system. Each level of prevention is described and examples are given of actual research-based programs that have data to prove their effectiveness. Leone et al. conclude by discussing the costs of developing collaborative programs and they compare this to the exorbitant cost of delinquency to our society.

Summary

This monograph series is a resource that can increase awareness of the issues related to youth with disabilities in the juvenile justice system. Awareness is the first step toward systemic change and improved outcomes for youth. Although reactive and punitive approaches to juvenile delinquency may present a quick fix, such approaches can make juvenile delinquency worse rather than better in the long run. The mission of the juvenile justice system is to protect and rehabilitate youth in trouble, not merely to punish them. Punishment-based approaches are costly not only economically, but also in terms of the lives of the youth involved. When preventive interventions have been implemented and some youth still get into trouble, a more humane and more effective approach is to use the considerable resources of the juvenile justice system to build on the strengths of youth and their families, and provide acceptable and prosocial alternatives to destructive behavior. Positive and proactive approaches can help not only youth, but also whole communities, to flourish.

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